

Midsize Company Eliminates PBM Markup, ~~and Reduces~~ Pharmacy Costs by 67%



"The PBM's Management Fee is tThe #1 metric in evaluating Pharmacy Benefit Management proposals and getting to the lowest possible net cost is the PBM's Management Fee."

PBM Management Fee = AF (Administrative Fees) + DF (Dispensing Fees) + IC (Ingredient Costs) + MR (Manufacturer Revenue) – CD (Cash Disbursements)

Generating more than \$400 billion annually, the PBM industry~~The PBM industry generates over \$400 billion annually. PBMs offers an extraordinarily -very- valuable service, one which provid~~ing pharmacy benefits to nearly 250 million Americans. Unfortunately, very few people outside of the industry fully truly understand how it makes them make its money at least until now.

Clients of a PBM clients include, but are not limited to, self-funded employers, insurers, unions, coalitions, and government agencies, just to name a few. All of the different PBM business models will profess how much money they can help plan sponsors save or that they are the most effective at improving -ways to improve your pharmacy benefit plan. HoweverBut, very few of them shareare sharing how much revenue they retain. Neither do they disclose their management fees. are retaining or the management fee.

Only two PBM business models will share their management fee - fiduciary or radically transparent PBM models. I mean, who are we kidding? Traditional, pass-through, and transparent PBM business models are for the most part the same. Do any of them reveal how much money they are e PBM is being paid for theirthe services it provides? Think about this for a second. Contracts between pharmacy benefit managers and pharmaceutical manufacturers and pharmacies are The contracts pharmacy benefit managers enter into with pharmaceutical manufacturers and pharmacies are pretty much set in stone. Unless a PBM significantly outperforms its contract, the terms between the PBMs and manufacturers will not change until the contract ends. has come to an end.

For a PBM to outperform a contract with a pharmaceutical manufacturer or rebate aggregator, there would need to be would require a significant change in market share, for example. Given this reality, If you believe this and you should, then what plan sponsors are really negotiating for during come renewal is what part of the discounts a PBM has secured you will allow that same PBM to keep. The part a PBM retains is its management fee.



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Commented [SL2]: Who are "plan sponsors"?

Commented [SL3]: What does this relate to? Are you saying the former statement isn't true?

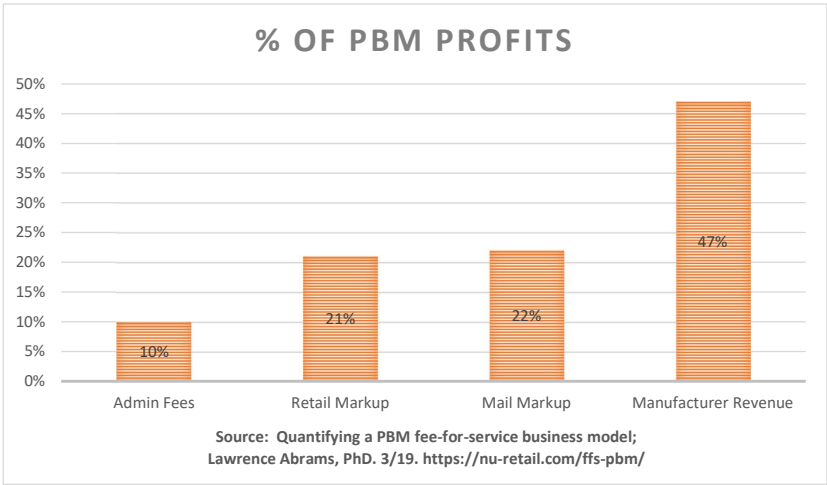
Commented [SL4]: I cannot make out your meaning here.

Let us assume you believe each PBM in a competitive bidding process can provide the services and support you require. Each PBM's offer should be ranked first based upon transparency in the contract language and second on the cost-effectiveness of the benefit design. The weight placed on each should be heavy (at least 60% when combined).

The primary reason an organization retains a PBM is to contain its pharmacy costs. PBMs do this in a variety of ways, including negotiating pharmacy discounts, pharmaceutical manufacturer contracting, drug utilization management and automating administrative services. Because PBMs offer varying degrees of transparency, some PBMs contain costs better than others.

The PBM works with the client to decide the pharmacy benefit that it will offer, including the drugs that will be covered, the beneficiary's cost-sharing requirements, and the pharmacy network. The client then retains the PBM to administer the pharmacy benefit for its members or employees. Often overlooked, in far too many PBM contracts, is how much cash the PBM actually generates for itself, on a per client basis, is information that is overlooked in far too many PBM contracts.

Is it unreasonable to know exactly how much revenue your PBM is keeping for itself on the services it provides to your organization? Traditional and pass-through pharmacy benefit managers alike will bark at this notion. The reality is clear: in other words, no matter how tight one believes a contract to be, most PBMs will find a way to overcharge unsophisticated plan sponsors.



RETAIL COST COMPONENTS

Administrative Fees



- These are the fees PBMs charge for claims adjudication (processing). They are often artificially low, from \$0.00 to \$1.50 per claim, but later augmented with cash flows from hidden sources. If you are not paying at least \$5.00 - \$10.00 per claim, you can be certain that the PBM is ~~assuredly~~ making up the difference elsewhere. This practice is frequently referred to as ballooning.
- Administrative fees associated with claims adjudication are different from the administrative fees paid by pharmaceutical manufacturers to PBMs. More on that in the rebate section of this white paper.

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Dispensing Fees

The professional dispensing fee, which compensates for costs beyond the ingredient cost of a covered outpatient drug, is gained at the point of sale or service each time a covered outpatient drug is dispensed. The Centers for Medicare & Medicaid Services (CMS) states that it only includes pharmacy costs related to ensuring that appropriate covered outpatient drug possession is transferred to a beneficiary. According to the CMS, reasonable expenses related to a pharmacist's time that fall under the category of pharmacy costs include, but are not limited to:

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- Looking up information about a patient's coverage on the computer
- Carrying out drug use reviews and preferred drug list review activities
- Measuring or mixing the covered outpatient drug
- Beneficiary counseling
- Physically giving the beneficiary their completed prescription
- Special packaging
- Overhead associated with facility and equipment maintenance necessary to the pharmacy's operation

The CMS also adds that administrative costs incurred by operating covered outpatient drug benefits—including systems costs for interfacing with pharmacies—are not a part of the professional dispensing fee. This detailed list of pharmacist activities included in the professional dispensing fee is intended to ~~reflect~~ demonstrate the ~~value of practitioner work~~ value of practitioners.

Where an acquisition cost-based system has been implemented in PBM retail pharmacy networks, the dispensing fees have been in the \$9 to \$15 range per prescription. Like administrative fees, dispensing fees can be artificially low. This ~~which~~ leads to the PBM making up for the lost revenue somewhere else.

Brand Ingredient Costs

Despite what the ~~is~~ name may ~~would~~ suggest, the AWP is not the average of the amounts actually paid by retail pharmacies or PBMs to wholesalers for a particular drug. Instead, it is a published wholesale price or "list price" suggested by the manufacturer of the drug. A wholesaler may sell specific drugs to all pharmacies at prices below the AWP or may grant a general discount to certain pharmacies.

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Thus, although PBMs frequently use the AWP as a cost basis for pricing purposes, ~~the AWP is frequently used by PBMs as a cost basis for pricing purposes~~, it does not represent the actual cost of acquiring the drug. It is merely a wholesale list price that can be used as a benchmark in comparing retail and wholesale prices. A PBM may contract with a retail pharmacy at AWP minus 15% and then offer its client an average AWP discount of minus 12%. This is referred to as differential contracting or differential pricing.



Differential pricing leads to spreads, which this paper discusses below. Retail pharmacies contract with pharmacy benefit managers at rates as high as AWP minus 22%; a sort of take it or leave it proposition. Again, typical discounts range anywhere from AWP minus 15% to AWP minus 18%.

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A spread is the difference between what a plan sponsor is billed and the amount the pharmacy is reimbursed for the same script. The PBM pockets the difference. The benchmark (i.e. AWP, MAC, or NADAC) being used to determine billing and reimbursement is only as important as full disclosure for into both sides of the transaction. Spreads are generally in the \$2.00 - \$4.00 range, but it is not uncommon to see them as high as \$200.00 for a single medication. In short, eliminate spreads at all costs. A senior leader at a large pharmaceutical manufacturer wrote this to us about lowest net cost.

“We have had numerous debates internally about how purchasers are asking for transparency vs. just the lowest price. Contract nomenclature often obscures the real price. We get asked often about direct contracting between manufacturer and employer. Lots of barriers but conceptually something that needs to be considered and they are not asking for a lower net price vs. the PBM...just better optics!”

Generic Ingredient Costs

Two basic sources of information are needed to permit an audit of the spread on a series of prescription transactions: (1) employers' line-item Rx transaction invoices received from PBMs each month and (2) dispensing pharmacies' itemized list of Rx transactions received with PBMs monthly payments. Generic discounts are often priced in one of two ways: as an AWP discount or at Maximum Allowable Cost (MAC). A large price gap usually exists between these two pricing elements.

The EDI 835 transaction set is called Health Care Claim Payment and Remittance Advice. It has been specified by HIPAA 5010 requirements for the electronic transmission of healthcare payment and benefit information. The EDI 835 is used primarily by Healthcare insurance plans to make payments to healthcare providers, to provide Explanations of Benefits (EOBs), or both. When a healthcare service provider submits an 837 Health Care Claim, the insurance plan uses the 835 to detail the payment to that claim, including:

- What charges were paid, reduced, or denied
- Whether there was a deductible, co-insurance, co-pay, etc.
- Any bundling or splitting of claims or line items
- How the payment was made, such as through a clearinghouse

A particular 835 EDI healthcare document may not necessarily match up one-for-one with a specific 837. In fact, it is not uncommon for multiple 835 transactions to be used in response to a single 837, or for one 835 to address multiple 837 submissions. As a result, the 835 is important to healthcare providers, to track what payments were received for services they provided and billed.



The best way for a plan sponsor to determine if they are paying a spread is to know what the pharmacy is being reimbursed for that same claim at the NDC level. The 835 Health Care Claim Payment and Remittance Advice is the tool you need for disclosure of this information and ultimately getting to lowest net cost. The type of network a PBM is running (i.e. acquisition cost, pass-through etc.) is less important than knowing what exactly the pharmacy is being reimbursed. That amount should match the plan sponsors billed cost.

Manufacturer Revenue (Rebates)

PBM's are limited only by their ingenuity in the types of rebates they receive from pharmaceutical manufacturers. In fact, most pharmaceutical manufacturers would rather not pay rebates. No matter what the PBM salesperson says, the only rebates that a PBM will pass-through are the rebates it is contractually obligated to pay. When a PBM says that they are passing-through 95% of the rebates, most likely it is they are referring to only the 95% of rebates it is contractually obligated to pay.

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Contract nomenclature must disclose, at a minimum, four types of rebates: formulary rebates, manufacturer administrative fees, price protection rebates and market share rebates. Quarterly rebate remittance reports must provide claim level payment information. Claim level detail for rebate payments includes fill date, quarter end date, claim number, NDC, unique pharmacy identifier, days' supply, quantity, guarantee classification, and amount paid.



How a PBM pays (i.e. per script, percentage, or fixed amount) rebates is far less important than what it pays. Plan sponsors are entitled to every penny a manufacturer is willing to remunerate for their drugs, whether for sales, access, or market share. You would be wise to refer to these monies in contract language as manufacturer revenue not just rebates. Without a trained-eye, radical transparency in pharmacy benefits will remain elusive even with the brightest minds in the legal field on the case. Radical transparency is defined as the self-elimination of all hidden [PBM] cash flows and full disclosure of PBM management fees, including their sources, on a plan-specific basis.

Poor Definition: Rebates mean retrospective formulary rebates that are paid to Acme pursuant to the terms of a formulary rebate contract with a Pharmaceutical Manufacturer and directly attributable to the utilization of certain Covered Benefits by Members of Client.

Better Definition: Rebates mean any proceeds that are paid to Acme pursuant to the terms of a contract with a Pharmaceutical Manufacturer and directly attributable to the utilization of certain Covered Benefits by Members of Client.

CLINICAL COST COMPONENTS

During hundreds of RFPs, no consultant or broker has ever asked TransparentRx for a signature-ready benefit design as part of our response. Never once during hundreds of RFPs has any consultant or broker ever asked TransparentRx for a signature ready benefit design as part of our response. We have not taken a poll, so we are not sure of the reason. Michael Critelli, former CEO at Pitney Bowes, wrote this to us few years back which might provide an explanation.



"...I am pleased that you wrote the particular essay I downloaded. Many corporate benefits departments do not understand that they are overmatched in negotiating with pharmacy benefit managers, as are the "independent consultants" who routinely advise them. The first step in being wise and insightful is admitting what we do not know, and you have humbled anyone who touches this field."

Some corporate benefit departments do not place enough emphasis on benefit design. There are four drivers of pharmacy costs: price, product mix, utilization, and cost share. Three of these se-four-drivers are covered in the benefit design. The fourth, price, is addressed primarily in the PBM contract.

Product Mix

Brand vs. Generic
Traditional vs. Specialty
OTC vs. Legend Drug

Utilization

Number of Utilizers
Days' Supply
Channel Mix (Retail vs. Mail)

A formulary is a list of drugs favored by the PBM for their clinical effectiveness and cost savings. Manufacturers of specialty and branded drugs often promise financial incentives to have their drugs featured on the formulary. Drug formularies can be open, incented, closed or hybrid~~s~~. There are five factors necessary for the makings of a good formulary. These include multiple enforcement mechanisms, a minimum five-tiered list of drugs, understanding of how the drugs are assessed, a firm dispute resolution process and an expedited appeal process.

An enforcement mechanism is particularly important. Certain drugs require prior authorization before they are covered under the drug benefit. Prior authorization is the PBM's pre-approval of a drug ~~by the PBM~~ before a pharmacy can dispense it. Not all enforcement mechanisms are created equally. Just because your PBM employs these tools does not mean they are being maximized or effective. Product mix is addressed by both the formulary and benefit design.

There are a number of tools in the utilization management tool bag ~~that~~which can have a significant impact on pharmacy costs. Those tools include (but are not limited to) therapeutic substitution, DUR edits, prior authorization, quantity limits, refill too soon limits, step therapy, formulary exclusions, compound drug limits or exclusions, exclusion of certain drug classes with over-the-counter (OTC) versions available, mandatory generic program, and predictive modeling/member segmentation. Each of these tools can be used with minimal disruption to members.

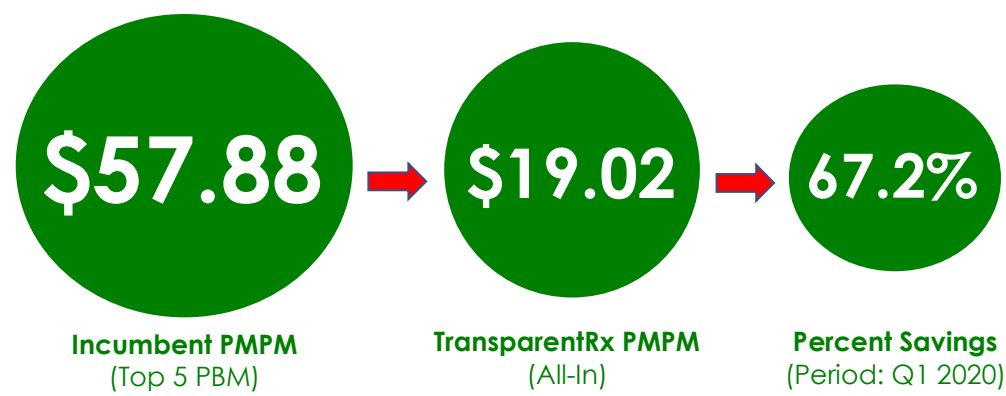
Factor in the actual benefit design, not questions about benefit design, on~~into~~ your PBM scorecard. At a minimum, it should be the same form the PBM uses to set up groups in the back-office. Sometimes even the PBM's benefit design form excludes important details, such as DAW codes, formulary exclusions, or even the formulary itself. If important information is missing, get it included. This is especially important when that information contributes to pharmacy costs and impacts the scorecard.

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Case Study



After going through a market check in 2019, a midsize client of TransparentRx was A midsize client of TransparentRx went through a market check in 2019, looking for a better deal than their incumbent PBM. The client hired a major consultant to evaluate offers from leading PBMs to determine who would provide the best deal. Despite ranking middle of the pack on the consultant's scorecard, TransparentRx won the business. We were able to demonstrate how transparency and the PBM's management fee impacts cost. Here were the results after the first three months: After the first three months, the following results were produced:



Brian Uhlig, a Senior Partner with Alera Group, wrote in response to his client's performance with TransparentRx, "...ridiculous numbers."

The \$38.86 PMPM difference (\$57.88 – \$19.02) is the incumbent PBM's management fee or what they were charging the client ~~forte~~ ~~provide~~ the pharmacy benefit management service. It is the undisclosed portion of the plan's final cost.

The incumbent PBM's management fee amounted to more than total ingredient costs. When compared to TransparentRx's fiduciary-model PBM (\$4.35 PMPM), the markup on the management fee, on a PMPM basis, was 793%!

A glass half-empty person will try to find holes in order ~~so~~ to invalidate these results. One could argue the results are based only on three months of data. PMPM is static unless a slew of new high cost claims are paid.

markup = $\frac{\text{profit}}{\text{cost} * 100\%}$

Cost	4.35 \$
Markup	793.333 %
Revenue	38.86 \$
Profit	34.51 \$

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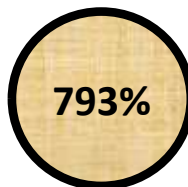
While total spend will undoubtedly increase throughout the course of the year, but PMPM will remain relatively unchanged. Also, the results were achieved prior to the economic and social impact of COVID-19 taking its toll on the economy and society in general. Finally, there was little to no disruption to the member experience. After the first 90 days, member support inquiries are fewer than 10 per week and general in nature. It's clear that a glass half-full person will recognize the speed at which pharmacy costs can be significantly brought down.

In recent years, the standard for analyzing the best PBM deal has been driven by two factors: (1) who offers the best AWP discount guarantees and (2) who offers the best rebate guarantee. Typically, these two factors are measured by way of a scorecard of some sorts. The scorecard measures the bidders' offers (AWP and rebate) against contractual definitions. The result is applied to the current drug spend to determine who has the best offer.

This type of scoring can often work in the favor of PBMs that lack transparency. Because the scorecard results can often be better, this type of scoring works in the favor of opaque PBM's offer. Contract nomenclature can facilitate the obfuscation of the real price. As a result, due to obfuscation of the real price in contract nomenclature, pharmacy spreads being retained in the offer or manufacturer revenue not being passed through can go undisclosed. revenue not being passed through go undisclosed. In these cases, the PBM will keep these Those undisclosed cash flows, categorizing them as are kept by the PBM and categorized as a service or management fees.

The revenue a PBM keeps for itself is referred to as its the PBM's management fee. In other words, it is the fee a PBM charges a client for the services it was hired to perform. PBM management fees are a hidden driver of pharmacy costs. While discount guarantees, rebates and clinical management are very important, they are also being used to distract purchasers from a key driver of their final plan costs - PBM management fees.

If you would like a free analysis of your current spend and how it would look with TransparentRx, reach out to a TransparentRx sales rep today at sales@transparentrx.com.



Commented [SL11]: Should this be "spending"?

Commented [SL12]: What period are you talking about here? After the COVID-19 crisis started? Need to clarify meaning and significance here.

Commented [SL13]: Did you mean "spending"?

